

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WHITE PLAINLY, WITH UNFAVORABLE IMPRESSIONS IS A PERMANENT RECORD

JUL 13 1934

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

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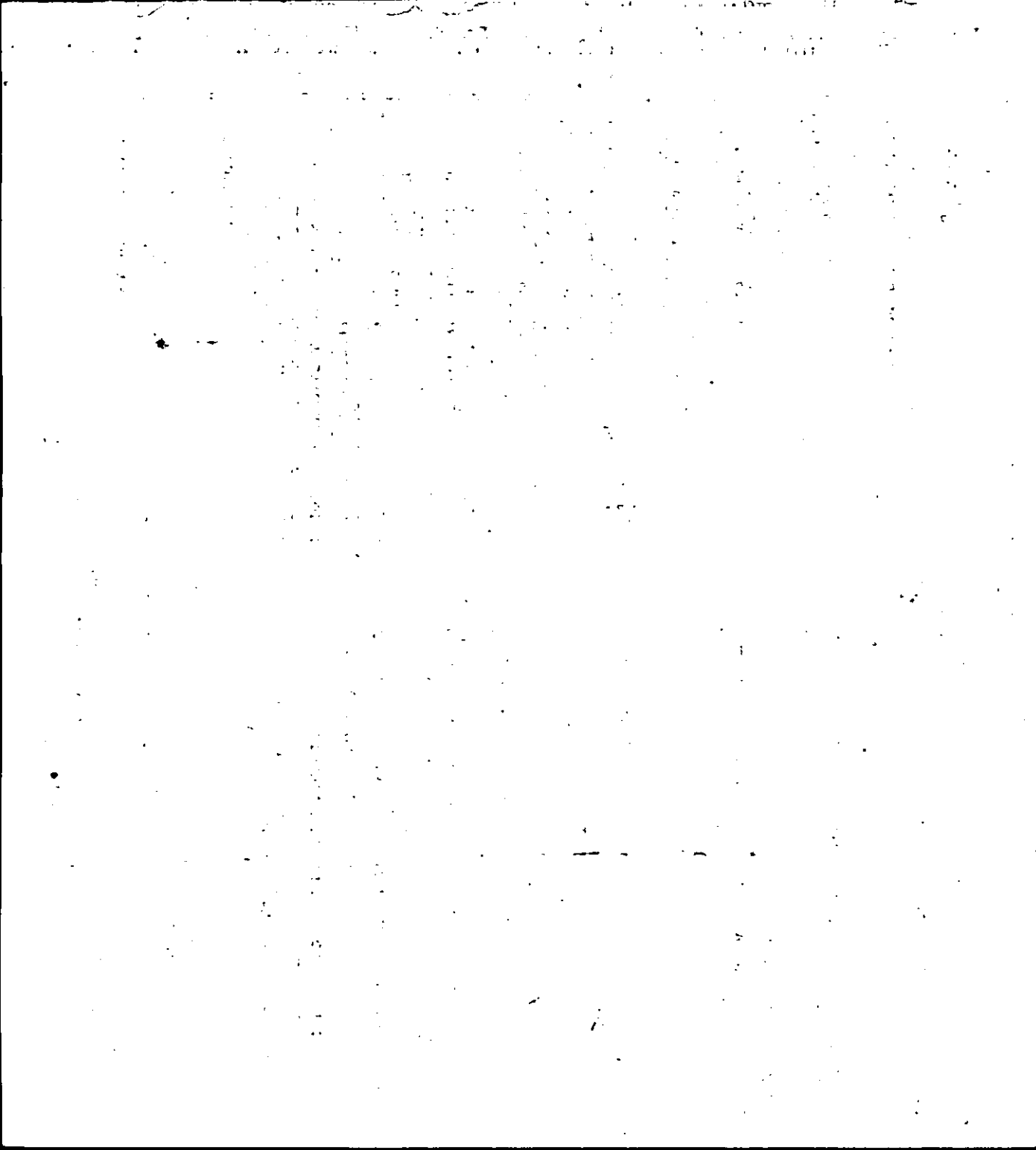
1. PLACE OF DEATH
74 County Nodaway Registration District No. 620
9 Township Rolls Primary Registration District No. 3031
7 City Maryville (No. _____ St. _____ Ward _____)
2. FULL NAME Fried Welling
(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Alice Welling
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 3-30-1871
7. AGE YEARS 63 MONTHS 3 DAYS - If LESS than 1 day, _____ hrs. or _____ min.
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. merchant
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bardolph Ill.
13. NAME David Welling
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio
15. MAIDEN NAME Bell Leighty
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Penn.
17. INFORMANT Alice Welling (ADDRESS) Maryville Mo
18. BURIAL, CREMATION, OR REMOVAL
PLACE Dak Hill Cem DATE 7-2 1934
19. UNDERTAKER Campbell Funeral Home (ADDRESS) Maryville Mo
20. FILED 7-2 1934 Mamie E. Clardy Registrar.

MEDICAL CERTIFICATE OF DEATH

2. 21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-30 1934
22. I HEREBY CERTIFY, That I attended deceased from June 10 1934, to June 30 1934
I last saw him alive on June 30 1934. Death is said to have occurred on the date stated above, at 2:30 P. M.
The principal cause of death and related causes of importance were as follows:
Hypostatic pneumonia Date of onset _____
62 R
107 R
92 R
Other contributory causes of importance:
Cerebral hemorrhage
Name of operation none Date of _____
What test confirmed diagnosis? Examination Was there an autopsy? No
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____ 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury _____
Nature of injury _____
24. Was disease or injury in any way related to occupation of deceased? No
If so, specify _____
(Signed) Jess. Rowles _____, M. D.
(Address) Maryville Mo.



#2 *Not away*

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

WASHINGTON

E. T. McGaugh, M. D.,
Special Agent,
Jefferson City, Mo.

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Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Fred Welling
Who died at _____ on 6-30-1934
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex M Color or race W Single married, widowed or divorced: _____

Date of birth _____ Age: Years 63 Months 3 Days _____

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

Date deceased last worked at this occupation: Month _____ Year _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

Principal cause of death: Hypostatic Pneumonia
Bronchial Pneumonia

Other contributory causes of importance Cerebral Hemorrhage

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____

(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

Name of physician _____

Address of physician _____

Signature of Registrar Mamie E. Clardy - 7-2-34

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,

Reg. Dist. No. 625-

Primary Reg. Dist. No. 3031

E. T. McGaugh, M.D.
Special Agent.
M. R.

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